MINUTES
of the
SIXTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 6-8, 2013
State Capitol, Room 307
Santa Fe

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on November 6, 2013 at 8:45 a.m. in Room 307 at the State Capitol in Santa Fe.

Present
Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza (11/6, 11/7)
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan (11/7)
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Absent

Advisory Members
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto (11/6, 11/7)
Rep. Sandra D. Jeff (11/7, 11/8)
Rep. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. Sander Rue (11/6, 11/8)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson
Sen. Lisa A. Torraco (11/6, 11/7)

Rep. Phillip M. Archuleta
Rep. Paul A. Pacheco
Rep. Vickie Perea
Sen. William P. Soules

Guest Legislators
Sen. Michael S. Sanchez (11/6)
Rep. Christine Trujillo (11/7)

(Attendance dates are noted for members not present for the entire meeting.)

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Wednesday, November 6

Welcome and Introductions

Representative Madalena welcomed guests to the meeting and asked members and staff to introduce themselves.

Centennial Care Update
Julie Weinberg

Julie Weinberg, director of the Medical Assistance Division (MAD) of the Human Services Department (HSD), gave committee members a presentation on plans for implementation of Centennial Care simultaneous with Medicaid expansion (see handout), which begins January 1, 2014. Ms. Weinberg said that the MAD has been working with Centennial Care's four managed care organizations (MCOs) since early spring, with attention to testing of claims processing and payments, provider network adequacy and care coordination. She assured members that the MAD is very focused on correct and prompt provider payments, as well as members' access to care. Medicaid recipients have until December 2 to select their MCO, she said. Those who do not select one on time will be auto-assigned. All members will receive notices in December confirming their MCO selections, but they still have a 90-day period to select a different MCO. The MAD has been doing "road shows", with more than 250 separate events attracting nearly 10,000 people. Along with program and education staff, representatives from the four MCOs also have attended every event. As of this report, Ms. Weinberg said, nearly 23,000 individuals had selected an MCO. Information about adult Medicaid expansion also was presented at these events. Most new applicants for Medicaid expansion will now receive just one notice of the opportunity to enroll, and if a Medicaid applicant does not qualify for Medicaid, the

individual's application will be sent to the New Mexico Health Insurance Exchange (NMHIX) for evaluation. From October 1 through 26, 2013, 19,000 persons applied for Medicaid, Ms. Weinberg said. The HSD will automatically enroll nearly 70,000 individuals who are currently enrolled in the State Coverage Insurance (SCI) program and who qualify for Medicaid coverage in 2014. Notices will go to those on the SCI waiting list informing them how to apply for Medicaid or NMHIX coverage.

Beginning in early 2014, hospitals, the Indian Health Service, tribal health facilities, urban Indian health centers, state prisons and county jails also will be allowed to conduct presumptive eligibility determinations for expanded Medicaid.

The newly enrolled adult group will receive a slightly different benefit package than other Medicaid members, the Alternative Benefit Plan (ABP), which includes preventive, mental health, substance abuse and dental services. The ABP will have some limitations on some services, such as physical therapy, and there will be some minimal copayments. Exempted from copayments will be members with household income up to 100% of the federal poverty level (FPL) and all preventive, behavioral health, prenatal and postpartum care and family planning services. Native Americans are not subject to copayments of any kind, Ms. Weinberg said.

Pregnant women and medically frail individuals are exempt from the ABP and can choose either the ABP or the SCI. Those persons on the SCI waiting list will be notified about Medicaid expansion. There really is no wrong door here, Ms. Weinberg said.

Ellen Pinnes

Ellen Pinnes, attorney and health policy consultant, told committee members that Centennial Care combines Medicaid into a single program through a new Section 1115 waiver approved by the federal Centers for Medicare and Medicaid Services (CMS) (see handout). Almost every part of the Medicaid program and almost every Medicaid enrollee will be affected, said Ms. Pinnes, resulting in both positive and negative changes and a lot of unknowns. Ms. Pinnes stated that her presentation was intended to highlight concerns and issues behind the changes that will happen all at once and affect up to 500,000 enrollees. There will be fewer MCOs, and there are questions about whether all four MCOs will have the experience or ability to administer all services.

Ms. Pinnes wondered whether "carving in" behavioral health to physical services actually integrates health care services. While care coordination is a key element of the new Centennial Care, Ms. Pinnes stated that it is not exactly clear how it will work or whether it will improve on the current system. Picking a new MCO can be a complicated process, Ms. Pinnes said, and the HSD is not offering assistance regarding plan selection. Income eligibility for family planning and breast/cervical cancer treatment without copayments has been reduced to 138% of the FPL. On the positive side, 12-month continuous eligibility reduces the "churn" in and out of the Medicaid program and reduces administrative burdens, she said. Originally, the HSD wanted mandatory enrollment for all Native Americans, but the tribes opposed this and the CMS

disapproved it. The devil is in the details, Ms. Pinnes concluded, and many of the details have been shrouded in secrecy. Development of the program has not been transparent, details are still emerging and much is still unknown, she said. Implementation work groups were internal to the HSD, Ms. Pinnes said, and there was limited opportunity for stakeholder input or participation.

Jim Jackson

Jim Jackson, executive director of Disability Rights New Mexico, addressed concerns about Centennial Care for elders and persons with disabilities (see handout). The key feature of Centennial Care is that the MCOs are to provide nearly all services to nearly all populations, Mr. Jackson said, including elders and people with disabilities needing long-term services, behavioral health services, including mental health and substance abuse, and service coordination and case management for people with higher levels of need. The only exception, he said, is that MCOs will not provide developmental disabilities waiver services but will provide health services for this population. There will be increased access for community-based long-term services, as the Medicaid expansion will cover people up to 138% of the FPL. Services now available only through the coordination of long-term services "c" waiver will be available to everyone who is income eligible and needs "nursing home level of care" through the "community benefit", he said. There is, however, a built-in barrier in the community benefit, Mr. Jackson noted. Services that any individual can receive will be capped at nursing facility cost, discriminating against persons with more severe disabilities and higher levels of need. These individuals may be forced into nursing facilities if they can find a facility that will accept them.

There will be greater opportunities for self-direction with many community-based services, Mr. Jackson said, with MCOs financially responsible for those services and for providing consumers with support and assistance for self-direction. The new CMS waiver required the HSD to submit an "Independent Consumer Support System" (ICSS) plan for individuals receiving long-term services, but that has been delayed and will not be in place until January 2014, too late to help current beneficiaries who must choose an MCO by December 2, Mr. Jackson said. With no help from the HSD or the ICSS program, more than 10,000 consumers will have to choose a new MCO on their own, with little information about what providers are in each network. Regarding behavioral health services, it is unclear how the coordination of care will be delegated to "core service agencies", since New Mexico's current system has been turned upside down, Mr. Jackson said. How the desired "holistic" integration of behavioral health with physical health will be achieved following the transfer of the behavioral health system to Arizona companies is also unclear, he said. The Medicaid expansion will extend health coverage, including added service benefits, to large numbers of currently uninsured adults with mental illness, Mr. Jackson said, but it is not clear how this will be accomplished.

Dorianne G. Mason

Dorianne G. Mason, staff attorney at the New Mexico Center on Law and Poverty (NMCLP), provided an overview (see handout) of the Medicaid expansion, the enrollment process, coverage and benefits and new opportunities for data collection. More than 170,000 adults between the ages of 19 and 64 are eligible for the expansion, Ms. Mason said, but at least

45% of these uninsured individuals do not even know about it. Significant and positive steps have been taken by the HSD to spread the word, but more than 90,000 individuals have not yet been brought into the system. Ms. Mason urged partnership with community groups and schools, "going where the people are", she said, and the provision of clear, accurate information from the HSD's Income Support Division workers, who need more training. She also urged improvements to the HSD web site to make it clearer and more user-friendly, and she recommended printed materials that are accurate, clear and easily digestible. The Medicaid expansion is funded 100% by the federal government for the first three years, Ms. Mason observed, and its rollout should not be administratively burdensome. Comments on the "alternative benefits package" for new Medicaid enrollees are due by December 6, 2013, Ms. Mason said, adding that she is pleased that dental benefits will be covered. Questions remain about how the HSD will track whether people are getting needed medical services, she said, and whether the provider network is adequate to provide them. Finally, Ms. Mason emphasized the importance of transparency in tracking and in public reporting data, including coverage disparities by race, ethnicity, gender, age and location.

Questions/Concerns

Committee members had numerous questions for the presenters, grouped as follows.

Clarification of MCO financial processes. One member had specific questions about MCO contracts and payment processes. When a provider makes a mistake in billing, what is the time line for correction and rebilling and payment? The situation with previous behavioral health providers has created concern about this, the member stated, adding that it has been rumored that some providers have had their contracts extended with no fee schedule attached. Ms. Weinberg said she did not know if this was true but that it is routine practice when a new program is created.

Behavioral health care coordination. A member asked for clarification of the behavioral health model within the MCOs. Ms. Weinberg said it is a fully integrated care model with care coordination. There is only one point of contact, one plan, one phone number and one place to submit claims. There are stringent call center requirements for the MCOs, Ms. Weinberg continued, and a consumer searching for services will be directed to an assigned care coordinator. The member expressed concern about a fragile population having to navigate through a bureaucracy. MCOs are not allowed to subcontract management, so they are responsible for the delivery of services, Ms. Weinberg said. Some MCOs have brought in expertise on behavioral health services, but they cannot contract these services out.

Concerns about OptumHealth's contract extension. Matt Kennicott, HSD external services director, responded to a member's question about the OptumHealth contract, which has been extended to June 30, 2014. The new contract is for management of the non-Medicaid side of behavioral health services. A request for proposals (RFP) for a new contract beginning July 1 will be sent out by the department soon, Mr. Kennicott said. The member pointed out that OptumHealth's original contract said it could not be extended more than four years, and it was signed July 1, 2009. The member believes that the contract has expired and the extension is

illegal. Ms. Weinberg explained that the extension, executed through the office of the HSD's general counsel, is for six months only and that it did not make financial sense to go through a full procurement process in order to cover that short time frame. The member asked that the HSD take another look at the validity of this contract and report back to the committee; $350 million is a lot of money.

Concerns about the gap in family planning services. Ms. Weinberg said the program for women who qualify for the breast and cervical cancer program will continue through October 2014, but family planning services for approximately 10,000 Medicaid consumers whose incomes exceed 138% of the FPL will cease as of December 31, 2013, and they will need to go to the NMHIX to obtain coverage. Another member asked about the purpose of the HSD's decision to eliminate family planning benefits; delaying or impeding reproductive exams and birth control could cost more in the long run, the member pointed out. It is not possible to be all things to all people, Ms. Weinberg replied, adding that there are many alternative ways to access contraceptives and family planning services.

Clarification of reimbursement for licensed mental health clinicians. A committee member told Ms. Weinberg about testimony at the previous day's Behavioral Health Subcommittee meeting that only independently licensed clinicians would be reimbursed by Medicaid, creating a shortage of mental health providers and placing a vulnerable population at risk. Ms. Weinberg asserted that this information was not correct. Current regulations do allow services to be delivered by nonindependents who are affiliated within a facility, she said; those nonindependent services are still covered within the proper setting, Ms. Weinberg said. The state agrees that there are concerns about access to care and whether there is a sufficient work force.

Reasons for adding ABP copayments. Another member commented that the Medicaid expansion is funded 100% by the federal government for the next three years and asked why the HSD added some copayments to beneficiaries of the expansion. Ms. Weinberg responded that the department tried to make this look more like a commercial plan, and it wanted the expansion population to have an experience like those who are not on Medicaid. It is adding complexity to the ABP without much benefit, the member countered.

Concerns about coverage for individuals in jail. Several members expressed concern about the large number of individuals in detention who would be primary beneficiaries of the Medicaid expansion, and one member urged that Medicaid be automatically reinstated upon the individual's discharge. Jails do not collect information like hospitals, nor do they perform discharge planning like hospitals, Ms. Weinberg said. The information technology involved for reinstatement is expensive. The median length of stay in jail for a person determined to be incompetent is 500 days, a member observed, and the state needs to take care of this population.

Approval of Minutes

A motion was made and seconded for approval of minutes for the committee meetings of September 4-6 and October 2-4; the motion passed unanimously.

Tobacco Use and Cost Task Force Report: Senate Memorial 22

Heather W. Balas, president and executive director of New Mexico First, presented a comprehensive final report and recommendations (see handout) to committee members from the Tobacco Use and Employer Costs Task Force. New Mexico First, a public policy organization that offers town hall meetings and public forums to help develop ideas for policymakers and the public, was contracted by Presbyterian Healthcare Services to manage the task force and its reports, Ms. Balas said. Task force membership included representatives from a wide range of commercial and insurance businesses, Native American tribes, health care facilities and associations, the tobacco industry and the University of New Mexico (UNM). Co-chairs were Senator Ortiz y Pino, sponsor of the memorial, and Senator Moores. Also serving on the task force were Representatives Thomson and Monica Youngblood.

According to statistics from the Department of Health (DOH), one in five New Mexico adults and one in four youths smoke, and there are higher rates of smoking among people who are unemployed or have lower incomes. The purpose of this task force was to explore the relationship between tobacco use and employer costs and to recommend changes in the law to decrease costs incurred by employers and employees due to tobacco use. Diane Snyder, executive director, Greater Albuquerque Medical Association, and chair of the task force's law and policy committee, along with Dr. Dona Upson, an internist at the UNM Health Sciences Center and chair of the health and workplace committee, presented the recommendations of the task force. After extensive review of data and considerable discussion among task force members, recommendations included the following:

- modify the Employee Privacy Act to revoke protection of smokers' rights so that businesses can choose whether to hire smokers;
- modify the Employee Privacy Act so that certain sectors for which smoking is particularly inappropriate (health care and education) are allowed to choose whether to hire smokers and to decide whether to prohibit smoking off-premises during work hours;
- require all health insurance plans to include comprehensive treatment for tobacco dependence in benefit packages;
- task the appropriate legislative committee to evaluate wellness programs, with particular focus on smoking cessation, to assess best practices;
- fund tobacco use prevention and cessation programs at levels recommended by the federal Centers for Disease Control and Prevention (currently $23.4 million) and reinstate cessation and prevention funding for collaborative work with tribes and the Indian Affairs Department;
- increase excise taxes on cigarettes and non-cigarette tobacco products, including electronic cigarettes;
- provide tax credit incentives to employers offering evidence-based tobacco cessation programs;
- encourage voluntary policies to expand smoke-free workplaces, including outdoor spaces; and

- encourage employers and unions to collaborate in efforts to decrease tobacco dependence.

Ms. Snyder and Dr. Upson referred committee members to detailed information contained in the task force report, including pros and cons for each recommendation and the percentage of task force members' agreement with each, which ranged from 100% to 42%. In summary, the issues and policy responses are complicated and controversial, but despite the complexity, the task force was able to identify concrete reforms for consideration by the legislature and the private sector.

Questions/Concerns

The excise tax on cigarettes in New Mexico is $1.67 a pack. Tribes have a $.75 tax, and they keep it, one member noted. Tribal entities have a monopoly, noted another, and collaboration with them is needed. There was some funding available to tribes for cessation, but that has been reduced; now tribes are asking that it be increased, Ms. Snyder said. A committee member who served on the task force said the charge of the task force was to figure out the cost of smokers to employers. It is better, the member said, to deal directly with smoking by providing cessation and wellness programs and taxing cigarettes rather than punishing smokers through reduced employment opportunities. Committee members discussed the popularity of e-cigarettes, which are being heavily marketed, and the fact that they are not regulated or taxed.

Liver Transplant Facility Update: House Memorial (HM) 48

Winona Stoltzfus, M.D., medical director of the Health Systems Bureau, DOH, reported to the committee progress on HM 48, which directs the DOH and UNM hospitals to conduct a feasibility study to determine steps necessary to create a liver transplantation institute in New Mexico. After careful consideration of specific criteria, an RFP was developed and sent out in August. There were five respondents, Dr. Stoltzfus said, all from out of state, and an award was made to Transplant Management Group in October. A site visit is planned in November, and completion of the study is expected by the end of December.

Older Adult Falls Task Force: House Joint Memorial (HJM) 32

Senator O'Neill and Representative Thomson sponsored HJM 32, which brought together representatives from the DOH, the Aging and Long-Term Services Department (ALTSD), the Pueblo of San Felipe, the Indian Health Service, UNM Hospital, the Veterans Administration Medical Center, hospice and several nonprofit organizations and a private citizen with a history of falls.

New Mexico leads the nation in deaths from unintentional injuries, and falls are the leading cause of injury-related deaths, hospitalizations and emergency room visits among older adults, according to the executive summary (see handout) of the HJM 32 task force report. The task force was formed to evaluate New Mexico's current approach to community-based fall prevention and to develop evidence-based strategies for effective change. Presenters of the task force recommendations included Michael Landen, M.D., state epidemiologist, DOH; Janet Popp,

physical therapist and gerontologist, Brookdale Place and UNM; and Spanda Bhavani Johnson, wellness director of the Good Samaritan Society, Manzano del Sol Village in Albuquerque.

Dr. Landen served as chair of the task force and described the burden of fall-related injuries and deaths among New Mexico adults ages 65 and older with a series of graphs and charts detailing hospitalizations, medical costs, lost wages and death rates. Older adult falls are in the top three causes of injury, with a rate of 100 out of every 100,000 of that population falling annually and 75 to 85 of them dying from their falls. Even if the individual recovers from the fall, Dr. Landen said, it can herald a major change in someone's lifestyle. Fall injuries can make it hard for older adults to live independently, and many older adults who fall, even when not seriously injured, develop a fear of falling.

Ms. Johnson told the committee that falls can be prevented and that health professionals can refer patients to a program. Exercise interventions are not yet available in all communities, but the DOH has trained 65 instructors in Tai Chi for Better Balance, an exercise program recommended by the CDC that has been gaining traction nationally. Older adults need safe, effective classes taught by experienced and certified fitness instructors, Ms. Johnson said. In a survey of New Mexico senior centers, three are currently offering fall awareness programs, while 43 are not.

Ms. Popp presented the task force findings and a plan to reduce falls in New Mexico by increasing public awareness about modifiable fall risk factors, increasing health care provider awareness to help clients be more proactive and increasing access to evidence-based fall prevention programming. The task force is requesting a $1 million appropriation from the general fund to the DOH for fall prevention activities and to add a staff person to expand programming and education statewide, form collaborations, collect data and evaluate the impact of prevention programs. Falls are not a normal part of aging, Ms. Popp asserted; they can be prevented.

Questions/Concerns

Asked if other states have instituted a similar statewide fall prevention program, Ms. Popp said that there is not a lot of information available, but Connecticut has done so. Ms. Popp agreed to get budget information from Connecticut. One member was pleased with the task force's emphasis on reaching people in senior centers. Over the next decade, the legislature is going to be spending nearly $1 billion in capital outlay for senior centers, the member noted, and now is the time to help convert senior centers into wellness centers. MCOs need to be brought into this, as well. Another member noted that there were no representatives from the AARP on the task force and suggested that this organization, with its large membership, might be helpful. Another member praised the idea of a collaboration between the DOH and ALTSD.

Discussion of Dates for Final Meeting

Representative Madalena called the committee's attention to the fact that the scheduled dates for the final meeting of the LHHS (November 25-26) put many members in conflict with

other previously scheduled meetings, and he suggested new dates of December 19-20 instead. A motion to change the dates was made and seconded and passed unanimously.

Thursday, November 7

Welcome and Introductions

Representative Madalena reconvened the meeting at 8:45 a.m., welcomed attendees and asked legislators and staff to introduce themselves.

Health and Working Conditions of New Mexico's Agricultural Workers

Gail Evans, attorney and litigation director of the NMCLP, presented results of the center's 2012 survey on New Mexico field and dairy workers (see handout). The report maintains that many of New Mexico's agricultural workers labor in difficult, dangerous and abusive working conditions, perform backbreaking work in unsafe conditions and are paid extremely low wages. New Mexico's agricultural industry is no longer composed of the small family farms of the past, Ms. Evans said. While there are more than 20,000 farms in New Mexico, 10% (about 2,000) generate 90% of the industry's income from farming and employ almost all of New Mexico's 15,000 to 20,000 agricultural workers. Laws of the past, which were meant to support small family farms, are now used by large agribusiness to maximize profits, Ms. Evans said, such as the following:

- exclusion of dairy workers from the state's minimum wage;
- exclusion of all agricultural workers from federal and state overtime protections;
- exclusion of all agricultural workers from the right to participate in collective bargaining; and
- exclusion of many agricultural employers from enforcement and oversight of the New Mexico Occupational Health and Safety Bureau (OHSB).

New Mexico farm workers' average household income, according to this survey, is $8,978, while the national average is $17,500 to $19,999. Wage theft is rampant, according to survey respondents, with 67% reporting being victims of working off the clock, being assessed illegal deductions or not being paid at all. Nearly 20% said employers had failed to report their income to the Social Security Administration. Ms. Evans and Maria Martinez Sanchez, staff attorney at the NMCLP, presented a video that detailed the stories of farm workers in New Mexico, including individuals who had been injured on the job. Farming has changed in New Mexico over the last 20 years, Ms. Evans said, with the large farms bringing in a lot of profit. She listed cattle, dairy, pecans and hay as the top four categories of agricultural production. When the NMCLP's efforts to change state minimum wage laws to include these workers were rebuffed in the state legislature, the group went to court, Ms. Evans said, asserting that the exclusion was discriminatory and thus a violation of the Constitution of New Mexico. In 2011, the court struck down the exclusion, Ms. Evans said, and now the Workers' Compensation Administration (WCA) is waiting for a higher court to agree. In the meantime, the NMCLP also proposed that state funding be appropriated to allow the OHSB to go into smaller farms to

investigate dangerous conditions and pervasive exposure to pesticide poisoning, Ms. Sanchez said.

Recommendations of the NMCLP study include the following:

- amend the state's Minimum Wage Act to include dairy workers and overtime protections of all agricultural workers;
- pass new laws that give agricultural workers the right to participate in collective bargaining, allow the OHSB to enforce health and safety laws on farms with less than 11 employees and to mandate breaks and shade for field workers; and
- support comprehensive immigration reform to allow undocumented farm workers and their families to earn legal immigration status and citizenship.

This has been a five-year campaign, Ms. Evans said. The NMCLP is requesting that the committee send a letter to the governor and to the WCA, asking them to enforce the court ruling on the minimum wage.

Questions/Concerns

One committee member wanted clarification on current dairy worker protections. Ms. Evans said that dairy workers are covered by the federal minimum wage, but because of exclusions in state law, they are not entitled to overtime, which is a regular feature of dairy work. The member asked for copies of Arizona, California and Colorado worker compensation laws, which have more protections written into them. Workers' compensation insurance is based on payroll contributions into the system, Ms. Evans said. The $5 million to $10 million it would cost to cover New Mexico workers is one percent of the industry's reported annual profit, she said; this cost is not in dispute. Workers' compensation only applies to employers of three or more people, regardless of whether they are family members, Ms. Evans said; the minimum wage applies to seven or more full-time employees during a quarter. Another member asked why this has not been passed in the legislature. The agricultural lobby has prevailed, Ms. Evans answered.

One committee member who represents a district with a number of dairy farms said she knows how narrow a dairy farm's profit margin is and that before supporting a letter to the governor, she would want to hear from the other side. Several other members agreed that there are two sides to every story. A motion was made to send a letter to the New Mexico Legislative Council asking that a subcommittee of the Water and Natural Resources Committee be formed to examine this issue and reach some kind of consensus. Ms. Evans informed members that there was a memorial several years ago and a task force formed that met for two years. The NMCLP is not asking the legislature to amend the provision to conform to the court ruling, but rather to provide dairy workers shade, overtime, a minimum wage and the ability to organize. These are things that could be done now. The other side of the story has been told, Ms. Evans asserted. A member expressed empathy for these workers, stating that on tribal lands, there is a tradition of working in the field all day long. Tribes do not hire anyone from outside but do it all themselves, and it is very hard work. He thinks forming a subcommittee to explore this issue is a good idea.

The member's motion to ask the New Mexico Legislative Council to establish a subcommittee was then seconded and passed.

Parkinson's Disease and Pesticide Exposure: HM 42

Heidi Krapfl, M.S., chief of the Environmental Epidemiology Bureau, DOH, provided the committee with a handout summarizing data that eight epidemiologists from her bureau extracted from published studies and peer-reviewed journal articles on Parkinson's disease and pesticide use. This report is in response to the literature search requested in HM 42 (2013). Ms. Krapfl also presented the final report of HM 42, including the appendices with detailed information about specific chemicals and their uses (see handouts).

Representative McMillan, M.D., told the committee that he introduced HM 42 to ascertain whether science supports the general assumption that there is a connection between pesticide exposure and Parkinson's disease.

Data were summarized into two main categories, Ms. Krapfl said, pesticide exposure with genetic interactions and pesticide exposure without genetic interactions. The total number of articles selected for review was 1,577, and 104 studies were included for full review and analysis. Pesticides were categorized, and it was determined as best as possible how the exposure occurred. With agricultural use of pesticides, six results demonstrated statistically significant association with Parkinson's disease and eight did not. With other occupational uses of pesticides, nine results demonstrated statistically significant evidence of an association and seven results did not. With residential use of pesticides, including gardening, there were six results, three demonstrating statistically significant evidence of association and three that did not. In the category with use not specified or mentioned, there were nine results demonstrating statistically significant evidence of association and 16 that did not.

Ms. Krapfl said the New Mexico Department of Agriculture does not have data on the use of pesticides and where they are applied and thus does not allow a determination of risk of pertinent populations. Conclusions included the following.

In pesticide exposure without genetic interactions, evidence suggested an association between Parkinson's disease and pesticide exposure, but other factors were stronger predictors of Parkinson's disease than pesticides, including family history, head trauma and absence of smoking. There is good epidemiologic evidence for the association between general pesticide use and the development of Parkinson's disease, Ms. Krapfl said, but inconclusive evidence for the following specific uses: agricultural, including farming; residential use, including gardening; and other occupational uses. The report then listed recommendations regarding the use of pesticides and how individuals could protect themselves and others from exposure. Under the federal Worker Protection Standard, agricultural workers and pesticide handlers must be trained and informed about pesticides used on the establishment, and violations should be reported to the U.S. Department of Agriculture.

Questions/Concerns

There appears to be evidence of a connection, one member commented, but apparently New Mexico does not have historical data about where and in what amounts pesticides were used. Ms. Krapfl agreed, adding that dose and length of exposure also are important, but it is difficult to assess exposure retroactively. She advised that education and caution in the use of pesticides might be the most appropriate ways to help residents in the future; constituents can control the home environment, she said, and they can work with the New Mexico Department of Agriculture to find out what pesticides are being used where they live. During further discussion about the possibility of developing a Parkinson's disease registry, Ms. Krapfl said that it might be more useful if it included other diseases with a greater incidence that also are associated with environmental exposures such as metals and other non-pesticide toxic substances.

Dan Lorimier, a member of the Rio Grande Sierra Club and the HM 42 committee, said that this report is a major step in the ongoing effort to understand the relationship between pesticides and Parkinson's disease. He recognized Representative McMillan and the DOH for producing this exhaustive report.

NMHIX Update

Jason Sandel, vice chair of the NMHIX appointed by Speaker of the House of Representatives W. Ken Martinez, played a song for committee members, "Be Well", which is the name and theme of the NMHIX's advertising and public relations campaign to get New Mexicans to sign up for health insurance through the exchange. Mr. Sandel is a current two-term city council member in Farmington, where he also is the owner of Aztec Well Servicing. He provided members with a history of the legislation that established the NMHIX (see handouts), signed by the governor at the end of March, and the framework for implementation of the federal Patient Protection and Affordable Care Act (PPACA). The first meeting of the exchange board was in May, when key staff positions were filled and a plan of operation was passed and implemented. Since then, the NMHIX has contracted for a project manager, a technology partner and a communications partner, and Native American collaboration is staffed and under way, he said. The statewide web site, www.bewell.com, has been successfully launched. A statewide advertising campaign is on hold pending resolution of problems on the federal web site, Mr. Sandel said. As of October 31, 294 employers have completed the Small Business Health Options Program (SHOP) enrollment process, and a total of 925 employers have created an account in the SHOP. Individual enrollment remains unknown, since all individuals are passed directly to the federal site, HealthCare.gov. The transition from the NMHIX to Medicaid (and vice versa) has remained disjointed in that computer integration has not been clearly defined as yet, he said. According to the Kaiser Family Foundation, there are 193,000 people who might look to a state marketplace for health care coverage, with at least 118,000 of these likely eligible for tax credits or other assistance if enrolled through the NMHIX, Mr. Sandel said. The goal of the exchange is to enroll 84,000 within the first year, but delays in the use of the federal portal could hamper the state's potential for success. Board meetings are open to the public and generally held the third Friday of each month, Mr. Sandel said, with the next meeting scheduled in Roswell on November 15 and a board retreat planned in Taos in January.

Paige Duhamel, staff attorney with Southwest Women's Law Center, appeared at the meeting with Mr. Sandel and praised the considerable accomplishments of the NMHIX's "heavy lifting" in such a short time frame, but she wanted to provide remarks about needed improvements (see handout). Ms. Duhamel said that New Mexico ranks second in the nation for the rate of uninsured (448,000) and that approximately 229,000 of these are exchange-eligible, so there is a lot of work left to do. Ms. Duhamel is especially concerned about the apparent reluctance of the NMHIX board to appoint a stakeholder advisory committee, as charged in its enabling legislation. The NMHIX had proposed an advisory committee made up solely of its contractors, which would exclude many of the voices that the legislature intended to include, she said. Also of concern is the amount of funding for enrollment activities and outreach: out of the total $6,593,500 that is allocated, 65% is being spent in hospitals and health care clinics, meaning only those currently needing or seeking medical services are being reached. Ms. Duhamel said that the NMHIX must do better in funding outreach to healthier New Mexicans in order to better balance its enrollment. She also disagrees with the amount of funding dedicated to public relations and marketing: $7.5 million is already contracted and another $5 million is being sought from federal funding, bringing the total to $12.5 million — twice the level of in-person outreach and enrollment assistance. That extra $5 million would be better used to fund the state's community health worker programs to do education and outreach in communities, she said. Lastly, Ms. Duhamel urged the legislature to fund an actuarial value study to establish a basic health plan option for the exchange, since health insurance may not be affordable to many individuals even at subsidized rates.

Questions/Concerns

Mr. Sandel was asked about the $1.5 million for a Native American service center. The HSD was not able to tell him where those funds are, he said. A member asked if the funds had been expended elsewhere; Mr. Sandel did not know. Another member made a motion to send a letter to the HSD regarding accounting for the grant funds intended for a Native American service center and to request an answer prior to the final meeting of the committee on December 19. The motion was seconded and passed unanimously. A member noted that the NMHIX had received $100 million in grant funding and wondered why the Procurement Code was not being used. Mr. Sandel said that the NMHIX was specifically exempt from the Procurement Code because of limited time lines, but that it was following the intent. Another member had concerns about accounting at the NMHIX. Mr. Sandel said the NMHIX board is now expecting a monthly check register with details of each expenditure, so all of that information will be available. Queried about the Native American Advisory Commission, Mr. Sandel said there has been a lot of conversation about how to move forward because the NMHIX is not a state agency and cannot engage with tribes in a government-to-government manner, but it has Native American consultants and the NMHIX is pleased with the collaboration that has occurred since August. Nominations for the commission have been received, he said.

Lack of integration of the NMHIX with Medicaid enrollment is a continuing concern for several committee members. Ms. Duhamel said that HSD outreach events were focused on Centennial Care and not on Medicaid enrollment. The HSD has dragged its feet on Medicaid

enrollment, she asserted, so it has no funding available for this; but, fortunately, a lot of the navigators are also familiar with Medicaid eligibility. A committee member noted that the "elephant in the room" was Public Consulting Group (PCG) and asked if there was not a single New Mexico company that could have done this job. Tony Kerk of PCG, sitting next to Mr. Sandel at the presentation table, was introduced by Mr. Sandel. PCG, based in Boston, has a contract with the NMHIX to provide logistical services. It is the same company that conducted an audit for the HSD on 15 behavioral health providers. Mr. Kerk said that he has no knowledge of his company's other practices but that PCG does have a great deal of experience with insurance exchanges. PCG was chosen through an RFP, Mr. Sandel said.

A member asked Mr. Sandel about the New Mexico Medical Insurance Pool, which has about 10,000 members, many of whom will be moved into the NMHIX. Approximately 1,500 of these individuals will be covered by the federal government through the PPACA; 3,500 will probably be eligible for Medicaid expansion, and 5,500, many of whom are seriously ill but cannot be denied coverage, will go to the exchange, Mr. Sandel said. They will be moved progressively over time through December 2015 so as not to "crater" the NMHIX, he said.

Chiropractic Physician Primary Care Delivery

Steve Perlstein and Robert Jones, both chiropractic physicians, made a presentation to the committee (see handout) regarding allowing advanced chiropractic physicians to become team players in alleviating the shortage of primary care physicians. Dr. Perlstein cited a Legislative Finance Committee (LFC) report to the DOH describing the aging population and the growing shortage. Among other recommendations, it stated that health care service delivery models must evolve to adequately address New Mexico's health care needs. What Drs. Jones and Perlstein are seeking, on behalf of the New Mexico Chiropractic Association, is a change in the scope of practice for advanced chiropractic physicians to give them limited prescriptive authority as primary care providers.

There are nearly 500 licensed chiropractors in New Mexico, Dr. Perlstein said, and about 30% have undergone the advanced practice certification program, which involves 90 hours of additional training. He said the drugs that they are interested in being able to prescribe are those most commonly found in primary care, such as those used by a physician assistant: codeine in cough syrup, a drug for back pain, headaches or strep. Right now Dr. Perlstein may see a patient with any of these symptoms but would have to refer the patient to a colleague in order to get a prescription. Chiropractic physicians do not just do adjustments anymore, Dr. Perlstein said. He has to make sure that low back pain is not cancer or a prostrate problem, and diagnosing this is within his current scope of practice. He would then refer the patient for treatment.

In an exchange of ideas with a physician who is also a member of the committee, Dr. Perlstein asserted that most in his profession are moving more toward an evidence-based practice, and he agreed that expanded prescriptive authority would need to be evidence-based. Treatment plans involve visits several times a week, and a patient will start treatment but then stop. It is like not taking an antibiotic for its full course, he said.

Dr. Michael Pridham is an evidence-based chiropractor who is also licensed to teach. The health insurance industry has placed chiropractic in a separate category, he said, and patients are sometimes paying more in copayments than the chiropractor gets paid under the contract. Private insurance companies set the copayment, and high copayments are discouraging people from getting the care they need.

Ms. Johnson said that a bill was brought to the legislature in 2013, but it got tabled in committee, and talks with the superintendent of insurance stalled. "We are trying to create more access", she said.

Prospects for a School of Public Health

Deborah Helitzer, Sc.D., professor of family and community medicine and associate vice chancellor of research education at UNM, showed committee members a film made by students from New Mexico State University (NMSU) and UNM who want a school of public health. Public health is population health, interventions that make a difference to a large group of people, such as seat belts and school lunches (see handout). It has a lot to do with keeping people healthy, Dr. Helitzer said. Her handout included numerous examples of current public health initiatives in nutrition, diabetes prevention, substance abuse and mental health, multiple projects for tribal populations and domestic and sexual violence prevention. The College of Public Health at UNM is proposing a collaboration with NMSU to create a school of public health, which would broaden course offerings and increase capacity for public health research.

Access to Medical Marijuana

Dave Schmidt, director of the Drug Policy Alliance, announced to the committee that the DOH and Medical Advisory Board had recommended the addition of Parkinson's and Huntington's diseases and traumatic brain injury for inclusion for medical marijuana use, and the recommendations have been sent to Secretary of Health Retta Ward for approval.

Jessica Gelay, policy director of the Drug Policy Alliance, provided information to committee members (see handouts) about the "Freedom to Choose" campaign for veterans' access to medical marijuana. Employment discrimination against users is a problem, she said, and the need for physician education is huge. This program pays for itself, and it is the most regulated group there is, said Ms. Gelay, who brought several guests with her to tell their stories to committee members.

Staff Sergeant (Ret.) Mike Pell, a disabled U.S. Army veteran with posttraumatic stress disorder (PTSD), chronic pain and depression, was on 38 pills a day when he had been separated from his wife, was involved in a stand-off with police and was locked up in the psychiatric ward for three days. At that point, he decided to try medical marijuana, and he credits it with giving him his life back. Ms. Gelay said there are now 4,000 New Mexicans on medical marijuana for PTSD, and it reduces their need for pharmaceuticals and allows them to function in society and to regulate their own medication.

There are 23 licensed producers in New Mexico, and the number of plants they can grow is regulated. Now that New Mexico is reaching 10,000 registered users, there is a point where people will be forced into the black market, she said. An expansion of the number of plants can be done by regulation by the DOH. Ms. Gelay then introduced two professional producers that she brought with her to speak to committee members about their businesses.

Doug Speigel was licensed three years ago. The first year, he delivered for free, and during that time, one of his clients was a young man whose wife was dying of cancer. He got to know them both and saw that medical marijuana made her feel so much better. If her husband could not get it from Mr. Speigel, then he would have gone to the street. Eli Goodman, owner of New Mexican Natural Medicine, said there is an obvious safety factor involved with going to the streets, but just as important is the quality of the medicine. Mr. Goodman offers different strains, he said, and considers testing to be very important. Quality is unknown on the street; a tested material is much more controlled. It is no longer necessary to smoke marijuana because there are teas and many different edibles. No one here is promoting smoking, he added.

Public Comment

Fonda Osborne, president of the National Union of Hospital and Health Care Employees, urged committee members to reintroduce HB 445 from the first session, which failed by only one vote in the House Appropriations and Finance Committee. It would have required hospitals to have nurse staffing committees and develop plans based on patient acuity and ancillary staff. In June, her organization filed an official complaint against Christus St. Vincent Hospital regarding staffing. The DOH claimed it did not find any problems in four days of investigation. Staffing was increased to levels unknown in previous years, then the levels dropped again, Ms. Osborne said. Even though the state did not fault the hospital on staffing, it did cite the hospital for bedsores and falls. The intensive care unit at Holy Cross Hospital in Taos has gone from six to two beds, Ms. Osborne said. Safe staffing legislation would require the "bean counters" to consider patient care as well as profits. Representative Trujillo, the sponsor of HB 445, said she will carry this legislation again but will amend it to include release of information on staffing levels as a condition of state funding. Christus St. Vincent is a nonprofit and claims that, under the PPACA, it had to lay people off, Representative Trujillo said, but there is nothing in the PPACA that requires this. Senators Lopez and Rodriguez also indicated their support for this legislation.

Recess

The committee recessed at 5:45 p.m.

Friday, November 8

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:00 a.m., welcomed guests and asked legislators and staff to introduce themselves.

Corrections Health Care

Eric Chenier, fiscal analyst with the LFC, accompanied by Ruby Ann Esquibel, principal analyst, LFC, presented committee members with a PowerPoint presentation (see handout) describing the exponential growth in costs of medical treatment for New Mexico's prison population. Today's total expenditures are five times what they were in 1980, Mr. Chenier said, and with an aging prison population, costs are two to three times higher for prisoners 55 and older. There is also a higher incidence of behavioral health and substance abuse issues and chronic and infectious diseases. Mr. Chenier described details of the Corrections Department's contract with its health care provider, Corizon, Inc., chosen through a competitive RFP. Corizon is an out-of-state company, he said, but it uses all New Mexico providers. The Corizon contract cost $40.6 million in fiscal year (FY) 2013 and will cost $43.7 million in FY 2014 and FY 2015, a 7.6% increase.

Ms. Esquibel reported to the committee members that there are significant opportunities for savings due to Medicaid expansion. Many of the behavioral health services currently covered by the Adult Probation and Parole Division of the Corrections Department will now be 100% covered by federal funds, saving as much as $2 million annually, she said. In addition, Medicaid now will pay for inmates' inpatient hospital care after the first 24 hours, which could save the state as much as $30 million over the next decade. Expanding the use of telehealth services and geriatric parole in New Mexico could lead to additional savings, Ms. Esquibel said. UNM's Project ECHO is conducting work in prisons via telehealth, and the DOH's Public Health Program is providing some services in detention centers in Albuquerque and Dona Ana County, including screening, treatment of sexually transmitted diseases, prevention screenings, family planning services, opiate replacement therapy counseling and laboratory testing for HIV and hepatitis A, B and C.

Aurora Sanchez, deputy secretary of corrections, said that the annual cost per inmate is down now to approximately $5,000. The prisons have been using telepsychiatry for the past nine years, and they have seen savings from this, Ms. Sanchez said. Once an inmate is released, there are contract services available with the Interagency Behavioral Health Purchasing Collaborative through OptumHealth. These services will end on December 31, and the collaborative would like to extend them. Any savings will be redirected toward residential reintegration, Ms. Sanchez said; no one wants these folks to return to prison. There will be rough spots as the expansion is rolled out, she said, but, hopefully, lessons learned can be applied throughout the state. Brent Earnest, deputy secretary of the HSD, described Corrections Department efforts in pre-release Medicaid eligibility determinations and in training on presumptive eligibility. Being able to access Medicaid after release from prison could reduce the recidivism rate, he said.

Questions/Concerns

One member noted that geriatric release is complicated; often the inmate has nowhere to go, and it is important to provide whatever help is possible before the inmate leaves the system. There are many issues, but these folks deserve a chance, the member noted. Mr. Earnest said that leadership in corrections is embracing the same vision, but it will take a paradigm shift in

thinking for some people. Another member told Mr. Earnest that some legislators are interested in seeing all prisoners pre-qualified for Medicaid before release, and there probably will be a new bill introduced this session. If this does not get worked out, the member said, legislators will find the information technology (IT) funding to create a system for suspension of benefits. Suspension was an IT challenge during the rollout of the HSD's new ASPEN system, Mr. Earnest said, but the HSD is now able to achieve the goals of suspension through other approaches. The problem is not with prisons, the member said; presumptive eligibility can take place only once a year, and this is not workable for anyone who goes in and out of the corrections system.

Another member asked if treatment teams are being used for all prisoners who are being released. Ms. Sanchez said that they are. The release teams look at medical and behavioral health needs, jobs or education and social service needs. She then described a particular inmate who could be released today. The Corrections Department has tried diligently to place him, she said, but his family does not want him, no nursing home will take him and he is not sick enough to be in the hospital. He is being taken care of in prison because there is nowhere else for him to go.

Tasia Young, lobbyist with the New Mexico Association of Counties, described the issue of redirecting the counties' second one-eighth percent gross receipts tax to the HSD because sole community provider funding for hospitals ends on January 1, 2014. Counties object to this because it is an autonomy issue — local government is closest to the people — and an equity issue; there are winners and losers, and the funding will not come back to the local level in the same proportion. Mr. Earnest said that the HSD's proposal is a way to replace funding that is going away. He said he hopes there can be some kind of resolution between the counties and the HSD.

End-of-Life Choices

Barak Wolff, M.P.H., a former public health director, is co-chair of the executive council of Compassion and Choices. Dying is one of life's few certainties, he said, and it is not easy but is very important to discuss. Surveys show that 70% to 80% of people who are asked say that they would like to die at home, but only 30% actually do, Mr. Wolff said. Five percent of Medicare beneficiaries die each year, but 30% of the entire Medicare budget is spent on their last few weeks of life. Mr. Wolff provided a PowerPoint presentation to committee members (see handouts), starting with an overview of his organization, which is based in Denver. Compassion and Choices is the largest nonprofit working to improve care and expand choice at the end of life. It helps people plan for and achieve a good death, he said, and works to change attitudes, practices and policies so that everyone can have more control and comfort at the end of life. Compassion and Choices provides counseling, help with advance planning and state-specific advice, and its legal casework brings attention to end-of-life issues that affect everyone, Mr. Wolff said.

The Compassion and Choices presentation included detailed information about aid in dying in the State of Oregon. Aid in dying involves a physician providing a prescription to a

mentally competent, terminally ill adult who may ingest it to achieve a peaceful death if suffering becomes unbearable, Mr. Wolff said. In Oregon, during the 15 years since statute has allowed it, only 673 patients chose to secure the medication, and more than one-third of those did not consume it. The vast majority of patients were white and college-educated, had insurance and were dying of cancer or Lou Gehrig's disease. Mr. Wolff also provided background on federal and other state challenges to right-to-die legislation and details about the state's *Morris v. New Mexico* lawsuit, scheduled to go to trial on December 9.

Kathryn L. Tucker, director of advocacy and legal affairs for Compassion and Choices, is a graduate of Georgetown University Law Center, an adjunct professor of law at Loyola Law School and co-counsel for the plaintiffs in *Morris v. New Mexico*. Ms. Tucker provided extensive remarks about the case (see handout), her professional background and a history of the statutory and constitutional claims involved in this case. The suit has been brought by two physicians who treat cancer patients and a patient who has terminal cancer asking the court to recognize that physicians who provide a prescription for aid in dying to patients who request it should not be subject to criminal prosecution. In fact, the terminally ill patient, Asa Riggs, who is now in remission with advanced uterine cancer, was present at this meeting with Ms. Tucker and introduced herself to committee members. Saying she was a naturally shy person, Ms. Riggs nonetheless asserted that when she dies, she wants to be at home with her loved ones and wants her medical team to have every option available for her, including aid in dying. Ms. Riggs said she does not know if she will use it, but she wants it as an option. Ms. Tucker explained that aid in dying is not "assisted suicide", but rather a way to empower terminally ill individuals to have control over their manner of death. It is likely that the trial court decision in *Morris v. New Mexico* will be appealed, Ms. Tucker said, and that the case will ultimately be decided by the New Mexico Supreme Court.

Questions/Concerns

One committee member whose spouse is a physician encouraged broader education about palliative care. Physicians generally refuse all treatment when given a terminal diagnosis, the member said, adding that this is a good discussion that everyone should have. Ms. Tucker agreed that palliative education is very important, and when aid in dying is available, physicians are more eager to refer to hospice and to take additional training. Asked about support for aid in dying from physicians, Ms. Tucker said that many are supportive, but the American Medical Association is still opposed. Another committee member said that he had changed his opinion over the last several years about end-of-life choices and that he is supportive of the right to refuse further treatment. As a former pastor, he said, he cannot make that leap to support aid in dying. Ms. Tucker agreed that these are very personal, often religious, decisions. In Oregon, the state requires certification of terminal illness (an estimated six months or less to live) and mental competency. There are a lot of data from Oregon, Ms. Tucker said, and her organization does not know of any case where a terminally ill patient who chose to take the medication did not die quickly and peacefully. Typically, the patient is surrounded by family and self-administers the drug, then goes into a deep sleep with no signs of struggle. The patient is empowered to make this choice, and family members show none of the adverse mental health effects of a suicide.

Another member questioned whether physicians can "opt out" of participation in aid in dying if it is against their beliefs. Absolutely, said Ms. Tucker, and it is important to remember that no patient can do this through a surrogate; it is very clearly limited to the patient. Subtle pressure might be exerted on an individual to ingest the medication, another member speculated, and Ms. Tucker said that this was a concern at one time in Oregon, but there has been no evidence to indicate that this has happened. A member also brought up the possibility that the terminally ill patient might have a change of heart — that taking the medication might be a mistake. There are absolutely zero data that anyone who did this did not have full capacity, Ms. Tucker said. Some patients did live longer than six months, but there is no rush to make this choice, the most profoundly personal choice that anyone can make.

The ban has been raised, Ms. Tucker said, and the landscape of aid in dying is rich with data; none of the "parade of horribles" has come to pass. Those who are swayed by evidence can feel comfortable with the data, she said.

Peer-to-Peer Counseling: HJM 12 Report

Toby Rosenblatt, bureau chief of the Injury and Behavioral Epidemiology Bureau, Epidemiology and Response Division, DOH, presented the committee with a letter from Secretary of Health Ward regarding HJM 12, which requests that the DOH and the HSD incorporate peer-to-peer approaches into existing substance abuse efforts. Secretary Ward said that she regarded this approach as a diversion of resources for reducing substance abuse. There is no evidence-based scientific support for the efficacy of peer-to-peer prevention, the letter stated. It is an intervention, but not prevention.

Economic Development and Health Care Work Force

Dick Mason, chair of the legislative committee of Health Action New Mexico, presented information (see handouts) to the committee about the economic development potential related to expansion of New Mexico's health care work force. Mr. Mason also handed out summary of recommendations of the 2013 LFC report, "Adequacy of New Mexico's Health Care Systems Work Force", along with several other reports documenting the shortage of health care workers in New Mexico that will be exacerbated by the number of people who will now have health insurance under the PPACA. Mr. Mason said he is a corporate planner and industrial engineer, and he views this as an enormous opportunity for economic development. The expansion could create as many as 3,000 new jobs in the first year of implementation, he said. Senator Candalaria has drafted a senate joint memorial that requests the secretary of health to convene a health care work force working group to make recommendations to the governor and the legislature regarding development of the state's health care work force.

Senator Candelaria passed out copies of his proposed memorial, and several members had questions. One member asked why Senator Candalaria wants to ask the DOH to be in charge of this; perhaps another entity, such as a subcommittee of the LHHS, would have fewer issues of protecting its turf and could look at the issues in a more holistic and uniform way. Another member said that she supports the memorial but feels the proposed group should include

additional participants who do not work in state government. Senator Candaleria said that he would visit with the DOH again and possibly have a revised memorial ready for the last meeting of the committee in December.

J. Paul Taylor Early Childhood Task Force Report: HM 75

Kim Strauss, manager of the Brindle Foundation and chair of the HM 75 task force, said the group was made up of passionate advocates for children and included six members with Ph.D.s, many clinicians, four representatives of the military and numerous other stakeholders. The meetings began in April, and Ms. Strauss said she knows that the creation of this task force came with a certain amount of controversy, since New Mexico was deemed last in the nation for child welfare in the latest Annie E. Casey Foundation survey. Ms. Strauss presented the executive summary (see handout) and recommendations of the task force, but she also asked that its existence be extended by the 2014 legislature so that it could work cooperatively with state agencies and other advocates to develop details for execution of the early childhood mental health and child abuse prevention plan. The task force also requested that it serve to oversee the plan's implementation and identify areas unfunded that will require reallocating existing dollars or securing new funds for recommendation to the 2015 legislature.

Susan Burke, executive director of PB & J Family Services and vice chair of the task force, told committee members of critical cuts to the most vulnerable children, such as the 2009 cuts of up to 90% for at-risk children to the Family Infant Toddler program and 50% cuts for mental health programs. Families that end up costing the most to the state do not make it into the program, she said. There is no unified strategic plan with these cuts. Another task force member, Karen Armitage, M.D., associate clinical professor of family and community medicine at UNM, said there are people and teams and agencies that work on early childhood programs, but they are not connected, and, therefore, there are no referrals. The task force looked at a model where, if a child enters a place where the child is normally seen, but there are other risk factors, a provider can find out how that family is doing right now, fully utilizing already existing resources.

Following is a brief summary of HM 75 task force recommendations:

- establish community and state networks;
- identify at-risk children and families;
- increase linkages between primary and behavioral health;
- support comprehensive work force training;
- substantially increase the availability of high-quality, outcomes-based mental health services;
- promote programs that are evidence-based and meet standards for best practices;
- collect and make widely available critical data and support rigorous evaluation of programs; and
- decrease child abuse and neglect.

A second task force, this one an ad hoc working group convened jointly by Senator Ortiz y

Pino and Rachael Gonzales, a survivor of childhood abuse, and which met throughout the summer and fall of 2013, also presented its recommendations, which included the following:

- increase home visitation programs for young families;
- utilize unsubstantiated child abuse and neglect referrals as a portal for voluntary participation in services;
- improve interagency collaboration to end a "silo" effect;
- change the focus from punishment to rehabilitation;
- improve availability and usability of data and assessment of outcomes;
- create an early childhood committee as a component of every county health planning council;
- create a directory of successful, evidence-based approaches to prevention for expanding and replicating services;
- provide better-funded family planning, marriage and parents preparation programs;
- provide more effective drug and alcohol treatment programs;
- reduce the number of young people sent to juvenile corrections through a "probation subsidy" model;
- emphasize efforts to reduce poverty;
- establish an annual high-profile statewide summit on prevention of child abuse and neglect called by the governor; and
- create and support initiatives to foster children's awareness of physical, emotional and sexual abuse.

Volunteers who served on the ad hoc committee included several physicians, several private practitioners and representatives of nonprofit and faith-based family service organizations, community health and abuse prevention groups, UNM's Child Abuse Prevention Partnership and New Mexico Voices for Children.

Public Comment

Stewart Duban, a professor and pediatrician at UNM, said there is a need to keep the players together for this work force. "We check vision and hearing, but we do not screen one child on issues related to abuse and neglect", he said. There are 175,000 children under the age of five in New Mexico; 16,000 of them are served and 80,000 need the service. There needs to be a list of questions asked routinely at screening, he said, and it will not take a lot of time. These questions need to be asked at home visitation and by anyone who comes into contact with those children. The link between physical problems and abuse is a straight line, Dr. Duban said. Outcome data are absolutely essential but totally lacking.

Adjournment

There being no further business before the committee, the sixth meeting of the LHHS for the 2013 interim adjourned at 4:25 p.m.